SENATE, No. 20

STATE OF NEW JERSEY

216th LEGISLATURE

INTRODUCED MAY 14, 2015

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)
Senator LORETTA WEINBERG
District 37 (Bergen)

SYNOPSIS

The "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act."

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 12/11/2015)

AN ACT concerning health insurance, health care providers, and health care data and supplementing various parts of the statutory law.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. This act shall be known and may be cited as the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act."

2. The Legislature finds and declares that:

a. The health care delivery system in New Jersey needs reforms that will increase transparency in pricing for health care services, enhance consumer protections, create a system to resolve certain health care billing disputes, contain rising costs, and measure success with respect to these goals;

b. Despite existing State and federal laws and regulations to protect against certain surprise out-of-network charges, these charges continue to pose a problem for health care consumers in New Jersey. Many consumers find themselves with surprise bills for hospital emergency room procedures or for charges by providers that the consumer had no choice in selecting;

c. Notwithstanding that out-of-network benefits are a health insurance benefit enhancement for which insureds pay an additional premium, in recent years, out-of-network coverage has been used as a means to diminish consumer's health insurance coverage, exposing consumers to additional costs;

d. Health insurers and consumers continue to report exorbitant charges by certain health care professionals and facilities for out-of-network services, including balance billing, and in certain cases, consumers' bills are referred to collections, which contributes to the increasing costs of health care services and insurance and imposes hardships on health care consumers;

e. Health care providers and hospitals report that inadequate reimbursement from health insurers and government payers is causing financial stress on safety net hospitals, deteriorating morale amongst providers and reduced quality of care for consumers;

f. In order to collect necessary data to better implement reforms to the health care system to address these stated ills, it is necessary to establish a Healthcare Price Index system, or HPI, to collect data that can be used to fill critical information gaps as consumers, public policymakers, health care providers, researchers, quality improvement organizations, and carriers seek solutions for transforming health care delivery;

g. An HPI can systematically collect health care data to inform health policy initiatives and to further cost containment and quality improvement efforts;

h. An HPI would include medical, pharmacy, and behavioral health claims and be used to report cost, use, and quality information. To mask the identity of patients and ensure privacy, an HPI would be required to comply with the applicable provisions of the federal health privacy rule set forth in sections 160 and 164 of Title 45, Code of Federal Regulations, and with other proprietary requirements related to the collection and release of health care data;

i. By including all claims information into an HPI, New Jersey can gain a more complete picture of how much health care costs, how much providers receive for the same or similar services, the resources used to treat patients, and variations across the State, and among providers, in the total cost to treat an illness or medical event. In turn, businesses, consumers, providers, and policymakers can use the non-proprietary information to make better-informed decisions about cost-effectiveness and the quality of care;

j. An HPI is also an important source of information for designing and implementing an effective arbitration system for emergency and inadvertent out-of-network charges, and other payment and delivery system reforms, such as pay-for-performance, episode-of-care payments, global payments, medical homes, reference based pricing, and accountable care organizations;

k. Studies confirm that the United States spends significantly more on health care than other countries but, on the whole, does not produce better results for patients and does not receive equivalent value for each health care dollar spent;

l. The Institute of Medicine of the National Academy of Sciences has estimated that up to 30 percent of spending on health care in the United States is wasted; however, without comprehensive data on the costs, components, results, and demographics of care, it is difficult to identify and eliminate waste; and, without reliable information about how and where health care dollars are spent and how patients move through the system, states cannot design effective programs to address both unnecessary and inadequate care; and

m. It is, therefore, in the public interest to create the consumer protections provided for in this act and to establish an HPI and increase transparency in health care cost and utilization patterns in New Jersey to provide consumers, policymakers, providers, researchers, quality improvement organizations, and carriers with the information needed to support necessary health care reforms that will lead to a more cost-effective, high-quality health care system that benefits the citizens of this State.

3. As used in this act:

"Carrier" means an entity that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefits plan, including: an

insurance company authorized to issue health benefits plans; a health maintenance organization; a health, hospital, or medical service corporation; a multiple employer welfare arrangement; an entity providing or administering a self-funded health benefits plan; an entity under contract with the State Health Benefits Program and the School Employees' Health Benefits Program to administer a health benefits plan; or any other entity providing a health benefits plan.

"Commissioner" means the Commissioner of Banking and Insurance.

"Covered person" means a person on whose behalf a carrier is obligated to pay health care expense benefits or provide health care services.

"Department" means the Department of Banking and Insurance.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. For the purposes of this act, "health benefits plan" shall not include the following plans, policies or contracts: Medicaid, Medicare Advantage, accident only, credit, disability, long-term care, TRICARE supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), and hospital confinement indemnity coverage.

"Health care data" means data from a reporting entity relating to the provision, financing, and administration of health care, as applicable. Health care data shall include, but not be limited to, information regarding: medical, pharmacy, and behavioral health claims; health care utilization; health care safety and quality; health outcomes; health care providers; and costs.

"Health care facility" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

"Health care professional" means an individual, acting within the scope of his licensure or certification, who provides a covered service defined by the health benefits plan. "Health care professional" includes, but is not limited to, a physician and other health care professionals licensed pursuant to Title 45 of the Revised Statutes.

"Health care provider" or "provider" means a health care professional or health care facility.

"Inadvertent out-of-network services" means health care services that are: covered under a managed care health benefits plan that provides a network; and provided by an out-of-network health care provider in the event that a covered person utilizes an in-network health care facility for covered health care services and, for any reason, in-network health care services are unavailable in that facility.

"Index" or "HPI" means the Healthcare Price Index system established pursuant to this act.

"Medicaid" means the State Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"Medicare" means the federal Medicare program established pursuant to Pub.L.89-97 (42 U.S.C. s.1395 et seq.).

4. a. Prior to scheduling an appointment with a covered person for a non-emergency or elective procedure, and at least 30 days prior to the procedure, or upon scheduling the appointment if the procedure is scheduled to occur in less than 30 days, a health care facility shall provide a written disclosure form to the covered person on which the health care facility shall make the following disclosures, as applicable to each covered person's health benefits plan, in clear and understandable terms:

(1) whether the health care facility is in-network or out-of-network with respect to the covered person's health benefits plan;

(2) if the health care facility is in-network with respect to the person's health benefits plan, the health care facility shall disclose that:

(a) the covered person will have a financial responsibility applicable to an in-network procedure and not in excess of the covered person's copayment, deductible, or coinsurance as provided in the covered person's health benefits plan;

(b) unless the covered person, at the time of the disclosure required pursuant to this subsection, has knowingly, voluntarily, and specifically selected an out-of-network provider to provide services, the covered person will not incur any out-of-pocket costs in excess of the charges applicable to an in-network procedure; and

(c) any bills, charges or attempts to collect by the facility, or any health care professional involved in the procedure in excess of the covered person's copayment, deductible, or coinsurance as provided in the covered person's health benefits plan in violation of subparagraph (b) of this paragraph should be reported to the covered person's carrier and the relevant regulatory entity; and

(3) if the health care facility is out-of-network with respect to the covered person's health benefits plan, the health care facility shall disclose that:

(a) certain health care services will be provided on an out-of-network basis, including those health care services associated with the health care facility; and

(b) the covered person will have a financial responsibility applicable to health care services provided at an out-of-network facility, in excess of the covered person's copayment, deductible, or coinsurance, and the covered person may be responsible for any costs in excess of those allowed by their health benefits plan, and that the covered person should contact the covered person's carrier for further consultation on those costs.

b. The facility shall, prior to the procedure, and in terms the covered person typically understands, provide the covered person with a clear and understandable:

(1) description of the procedure;

(2) reasonable estimate of the costs for those services to be charged by that facility;

(3) information, if available, on all other costs related to the procedure including costs associated with any health care professionals or other services involved in the procedure and, if unavailable, the fact that the information is unavailable; and

(4) notice to the covered person to contact the covered person's carrier for further consultation on the costs of the procedure.

c. A health care facility shall, prior to the performance of the procedure, ensure that the covered person signs and returns the disclosure form to the health care facility, either electronically or in paper form.

d. If, between the time the notice required pursuant to subsection a. of this section is provided to the covered person and the time the procedure takes place, the network status of the facility changes as it relates to the covered person's heath benefits plan, the facility shall notify the covered person promptly.

e. The Department of Health shall specify in further detail the content and design of the disclosure form and the manner in which the form shall be provided.

5. a. Prior to scheduling an appointment with a covered person for a non-emergency or elective procedure, and at least 30 days prior to the procedure, or upon scheduling the appointment if the procedure is scheduled to occur in less than 30 days, a health care professional shall provide a written disclosure form to the covered person on which the health care professional shall make the following disclosures, as applicable to each covered person's health benefits plan, in clear and understandable terms:

(1) whether the health care professional is in-network or out-of-network with respect to the covered person's health benefits plan;

(2) if the health care professional is in-network with respect to the person's health benefits plan, the health care provider shall disclose that:

(a) the covered person will have a financial responsibility applicable to an in-network procedure and not in excess of the covered person's copayment, deductible, or coinsurance as provided in the covered person's health benefits plan;

(b) unless the covered person, at the time of the disclosure required pursuant to this subsection, has knowingly, voluntarily, and specifically selected an out-of-network provider to provide services, the covered person will not incur any out-of-pocket costs in excess of the charges applicable to an in-network procedure; and

(c) any bills, charges or attempts to collect by the provider, or any health care facility involved in the procedure in excess of the covered person's copayment, deductible, or coinsurance as provided in the covered person's health benefits plan in violation of subparagraph (b) of this paragraph should be reported to the covered person's carrier and the relevant regulatory entity; and

(3) if the health care professional is out-of-network with respect to the covered person's health benefits plan, the health care professional shall disclose that:

(a) certain health care services will be provided on an out-of-network basis, including those health care services associated with the health care professional; and

(b) the covered person will have a financial responsibility applicable to health care services provided by an out-of-network professional, in excess of the covered person's copayment, deductible, or coinsurance, and the covered person may be responsible for any costs in excess of those allowed by their health benefits plan, and that the covered person should contact the covered person's carrier for further consultation on those costs.

b. The professional shall, prior to the procedure, and in terms the covered person typically understands, provide the covered person with a clear and understandable:

(1) description of the procedure;

(2) reasonable estimate of the costs for those services to be charged by that professional;

(3) information, if available, on all other costs related to the procedure including costs associated with any health care professionals or other services involved in the procedure and, if unavailable, the fact that the information is unavailable; and

(4) notice to the covered person to contact the covered person's carrier for further consultation on the costs of the procedure.

c. A health care professional shall, prior to the performance of the procedure, ensure that the covered person signs and returns the disclosure form to the health care professional, either electronically or in paper form.

d. If, between the time the notice required pursuant to subsection a. of this section is provided to the covered person and the time the procedure takes place, the network status of the professional changes as it relates to the covered person's heath benefits plan, the professional shall notify the covered person promptly.

e. The appropriate professional or occupational licensing board within the Division of Consumer Affairs in the Department of Law and Public Safety shall specify in further detail the content and design of the disclosure form and the manner in which the form shall be provided.

6. a. A carrier shall disclose in writing to a covered person, at the time of enrollment in the plan, on the carrier's website, and upon request thereafter, for each health benefits plan offered in this State:

(1) a list of all providers that are in-network with respect to each health benefits plan, which list shall be updated at least every 20 days; and

(2) such other information as the commissioner determines appropriate and necessary to ensure that a covered person receives sufficient information necessary to make a well-informed health care decision.

b. If a carrier authorizes a covered health care service to be performed by an in-network health care provider with respect to any health benefits plan, and the provider or facility status changes to out-of-network before the authorized service is performed, the carrier shall notify the covered person that the provider or facility is no longer in-network as soon as practicable. If the carrier fails to provide the notice at least 30 days prior to the authorized service being performed, the covered person's financial responsibility shall be limited to the financial responsibility the covered person would have incurred had the provider been in-network with respect to the covered person's health benefits plan.

7. a. If a covered person receives medically necessary services at any health care facility on an emergency or urgent basis, the facility shall not bill the covered person in excess of any deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person's health benefits plan.

b. If a covered person receives medically necessary services at an out-of-network health care facility on an emergency or urgent basis, the health care facility shall not bill the carrier in excess of an amount that is the maximum of the payment range established by section 11 of this act. If the carrier and facility cannot agree on a reimbursement rate for these services within 30 days after the carrier is billed for the service, the carrier or health care facility may initiate binding arbitration pursuant to section 13 of this act.

c. If a health care facility is in-network with respect to any health benefits plan, the facility shall ensure that all providers providing services in the facility on an emergency or urgent basis accept reimbursement rates in accordance with section 8 of this act.

d. A health care facility that contracts with a carrier to be in-network with respect to any health benefits plan shall annually report to the Department of Health:

(1) the health benefits plans with which the facility has an agreement to be in-network;

(2) the number of health care professionals, by specialty, that provide services in the facility and whether those professionals participate in the same health benefits networks as the facility; and

(3) if any health care professionals that provide services in the facility are not in-network with respect to any health benefits plan in which the facility is in-network, confirmation that the facility has an agreement in place for professionals providing services in the facility to otherwise comply with section 8 of this act.

e. The Department of Health shall make the information collected pursuant to subsection d. of this section available to the Department of Banking and Insurance.

8. If a covered person receives:

a. inadvertent out-of-network services; or

b. medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis, the health care professional performing those services shall not bill:

(1) the covered person in excess of any deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person's health benefits plan; and

(2) the carrier in excess of an amount that is the maximum of the payment range established pursuant to section 11 of this act. If the carrier and the professional cannot agree on a reimbursement rate for these services within 30 days after the carrier is billed for the service, the carrier or professional may initiate binding arbitration pursuant to section 13 of this act.

9. a. The Commissioner of Banking and Insurance shall select an organization to maintain the Healthcare Price Index, in accordance with the terms of a written agreement which shall be entered into between the department and the organization, as further described in this act. The commissioner shall select an organization that possesses the capabilities to develop and implement policies and procedures for the collection, processing, storage, protection, management and analysis of health care data in accordance with this act. The organization, at the commissioner's direction, shall:

(1) collect the health care data from the carriers, which are also referred to herein as the reporting entities;

(2) if directed by the commissioner, incorporate other health care data sets such as Medicaid, Medicare or Hospital Discharge Data with the data collected and held by the organization;

(3) determine the standards and methods necessary for collecting health care data in a manner that minimizes the cost and administrative burden on carriers and utilizes uniform reporting systems for the collection of data on a scheduled basis;

(4) comply with the applicable provisions of the federal health privacy rule set forth in sections 160 and 164 of Title 45, Code of Federal Regulations, and with other proprietary requirements related to the collection and release of health care data;

(5) electronically publish on the department's website a list of median paid in-network claims which will be utilized to support the

payment range for any amount billed by an out-of-network health care provider and reimbursed by a carrier pursuant to section 11 of this act; and

(6) allow access to state entities and not for profit researchers that execute data use agreements with the department, which agreement shall be subject to review and approval by the commissioner, to utilize the non-proprietary portions of the index to measure trends and identify outliers within the State health care system related to: health care safety and quality; health care utilization; health outcomes; costs; efficiency and other areas in the public interest as identified by the commissioner.

b. The commissioner may solicit, receive, and accept grants, funds, or anything of value from any public or private entity and receive and accept fees or contributions of money, property, labor, or any other thing of value from any legitimate source to support the operation of the index, provided that: (1) the commissioner does not have reason to believe that the entity may have a vested interest in the decisions of the commissioner or the organization concerning the operation of the index; and (2) any funds received are disclosed on the department's website.

c. The purpose of the index shall be to serve as a source for useful, objective, reliable, and comprehensive health information designed to:

(1) identify and electronically publish annually the list of median in-network paid commercial claims for the payment range as established in section 11 of this act; and

(2) make health care data available to the State and to researchers to improve health care quality, reduce health care costs, and increase pricing transparency.

d. Carriers shall file that health care data determined by the commissioner to be necessary to carry out the purposes of this act. The form, medium, content, and frequency of the reporting shall be established by the commissioner but shall be reported not less than annually. Upon request by the commissioner, carriers shall report 2014 data to the department to be shared with the organization to effectuate the purposes of this act as soon as practicable upon the effective date of this act.

e. Each carrier, as a reporting entity, shall submit a completed health care claims data set for all covered persons who are New Jersey residents in accordance with the requirements of this section. Each carrier shall also be responsible for the submission of health care claims processed by any subcontractor on its behalf. The health care claims data set to be reported shall include, but not be limited to, the following files, as applicable: a medical claims file; a pharmacy claims file; a behavioral health claims file; a provider file; and a covered person eligibility file containing records associated with each of the claims files reported. The completed health care claims data set shall also include, but not be limited to, a

record of all claims, including the amount billed for by the provider and the amount paid by the carrier, for which information is submitted to the commissioner by carriers pursuant to sections 5 and 6 of P.L.1999, c.155 (C.17B:30-30 and 17B:30-31).

10. a. The agreement between the department and the organization shall specify the form, medium, content, and frequency of reporting of the health care data, consistent with the provisions of section 9 of this act, to the organization by carriers as determined by the commissioner to be necessary to effectuate the purposes of this act. The agreement shall be considered a contract for professional services pursuant to section 8 of P.L.2005, c.336 (C.52:34-10.8) due to the advanced actuarial and health care cost expertise and knowledge required of the organization.

b. The agreement between the department and the organization shall require the organization to submit sufficient information about the index and its use to enable the department to produce reports utilizing the data contained within the index, as the commissioner determines to be in furtherance of the purposes of this act.

c. The department shall, within 30 days of the date of enactment of this act, select a data storage contractor. The data storage contractor shall: (1) house and ensure the security of the data collected pursuant to this act; and (2) identify the format in which the data should be collected and analyzed to effectuate the purposes of this act. The data storage contractor shall be either: (1) an existing State entity that has the capacity to store and secure the data; or (2) selected pursuant to an existing State contract for data warehousing.

11. The agreement between the department and the organization shall require the organization, upon review and analysis of the health care data submitted for the purposes of the Healthcare Price Index, to establish a list of median in-network commercial paid claims for health care services in New Jersey. The organization shall update the list annually and the department shall publish it on its website. Using the list, the organization shall establish a reasonable and clearly defined payment range for any amount billed by an out-of-network health care provider and reimbursed by a carrier for out-of-network services provided on an emergency or urgent basis and as inadvertent out-of-network services. The payment range shall indicate a minimum and maximum allowable payment for any applicable service, which minimum shall be 75% and maximum shall be 250%, of the median paid in-network commercial claim for a service, as identified by the list of in-network commercial paid claims created pursuant to this section.

12. Notwithstanding any law, rule, or regulation to the contrary:

a. With respect to a carrier, if a covered person receives inadvertent out-of-network services, or services at an in-network or out-of-network health care facility on an emergency or urgent basis, the carrier shall ensure that the covered person incurs no greater out-of-pocket costs than the covered person would have incurred with an in-network health care provider for covered services. Pursuant to section 8 of this act, the out-of-network provider shall not bill the covered person, except for applicable deductible, copayment, or coinsurance amounts that would apply if the covered person utilized an in-network health care provider for the covered services.

b. A covered person may agree in writing to assign benefits that the covered person receives for health care services provided pursuant to subsection a. of this section to the out-of-network health care provider. If the benefits are assigned:

(1) any reimbursement paid by the carrier shall be paid directly to the out-of-network provider; and

(2) the carrier shall provide the out-of-network provider with a written explanation of benefits that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the covered person.

c. If inadvertent out-of-network services or services provided at an in-network or out-of-network health care facility on an emergency or urgent basis are performed in accordance with subsection a. of this section, the out-of-network provider may bill the carrier for the services rendered, in an amount that is within the payment range established by section 11 of this act. The carrier may pay the billed amount or attempt to negotiate reimbursement with the out-of-network health care provider.

13. a. If attempts to negotiate reimbursement for services provided by an out-of-network health care provider, pursuant to subsection c. of section 12 of this act, do not result in a resolution of the payment dispute within 30 days after the carrier is billed for the services by the out-of-network health care provider, the carrier or out-of-network health care provider may initiate binding arbitration to determine payment for the services.

b. The binding arbitration shall adhere to the following requirements:

(1) The party requesting arbitration shall notify the other party that arbitration has been initiated and state its final offer before arbitration. In response to this notice, the nonrequesting party shall inform the requesting party of its final offer before the arbitration occurs. Both final offers shall be within the payment range for the applicable service, as established by the organization, based on the organization’s review of the Healthcare Price Index pursuant to the provisions of section 11 of this act;

(2) Arbitration shall be initiated by filing a request with the department;

(3) The department shall contract with one or more entities that have experience in health care pricing. The department may utilize the entity engaged under the "Health Claims Authorization, Processing, and Payment Act," P.L.2005, c.352 (C.17B:30-48 et seq.), for arbitration under this act. Claims that are subject to arbitration pursuant to the provisions of this act, which previously would be subject to arbitration pursuant to the "Health Claims Authorization, Processing, and Payment Act," shall instead be subject to this act;

(4) The arbitration shall consist of a review of the written submissions by both parties, which shall include the final offer for the payment by the carrier for the out-of-network health care provider's fee, and the final offer by the out-of network provider for the fee the provider will accept as payment from the carrier; and

(5) The arbitrator's decision shall be one of the two amounts submitted by the parties as their final offers and shall be binding on both parties. The decision of the arbitrator shall include written findings and shall be issued within 30 days after the request is filed with the department. The arbitrator's expenses and fees shall be paid as provided in the decision. Each party shall be responsible for its own costs and fees, including legal fees if any.

c. In making a determination pursuant to subsection b. of this section, the arbitrator shall consider:

(1) the level of training, education, and experience of the health care professional;

(2) the health care provider's usual charge for comparable services provided out-of-network with respect to any health benefits plans;

(3) the circumstances and complexity of the particular case, including the time and place of the service;

(4) individual patient characteristics; and

(5) the usual and customary cost of the service in the county, including the list of median commercial paid in-network claims for the service as established by the Healthcare Price Index pursuant to section 11 of this act.

d. The interest charges for overdue payments, pursuant to P.L.1999, c.154 (C.17B:30-23 et al.), shall not apply during the pendency of a decision under subsection b. of this section and any interest required to be paid a provider under P.L.1999, c.154 (C.17B:30-23 et al.) shall not accrue until after 30 days following an arbitrator's decision as provided in subsection b. of this section, but in no circumstances longer than 150 days from the date that the out-of-network provider billed the carrier for services rendered.

e. This section shall apply only if the covered person complies with any applicable preauthorization or review requirements of the

health benefits plan regarding the determination of medical necessity to access in-network inpatient or outpatient benefits.

f. This section shall not apply to a covered person who knowingly, voluntarily, and specifically chooses an out-of-network provider for health care services.

14. On or before January 31 of each calendar year, the commissioner shall consult with the Department of the Treasury, the relevant professional and occupational licensing boards within the Division of Consumer Affairs in the Department of Law and Public Safety, and the Department of Health, to obtain information to compile and make publicly available, on the department's website:

a. A list of all arbitrations filed pursuant to section 13 of this act between January 1 and December 31 of the previous calendar year, including the percentage of all claims that were arbitrated.

(1) For each arbitration decision, the list shall include but not be limited to:

(a) an indication of whether the decision was in favor of the carrier or the out-of-network health care provider;

(b) the arbitration bids offered by each side and the award amount;

(c) the category and practice specialty of each out-of-network health care provider involved in an arbitration decision, as applicable; and

(d) a description of the service that was provided and billed for.

(2) The list of arbitration decisions shall not include any information specifically identifying the provider, carrier, or covered person involved in each arbitration decision.

b. The percentage of facilities and hospital-based professionals, by specialty, that are in-network for each carrier in this State as reported pursuant to subsection d. of section 7 of this act.

c. The list of the 50 most common median paid in-network Current Procedural Terminology (CPT) codes as established by the HPI pursuant to section 11 of this act.

d. The number of complaints the department receives relating to out-of-network health care services.

e. The number of and description of claims received by the State Health Benefits Program and the School Employees' Health Benefits Program for in-State emergency out-of-network health care and inadvertent out-of-network health care.

f. Annual trends on health benefits plan premium rates, total annual amount of spending on inadvertent and emergency out-of-network costs by health benefits plans, and medical loss ratios in the State to the extent that the information is available.

g. The number of physician specialists practicing in the State in a particular specialty and whether they are in or out-of-network with respect to the carriers that administer the State Health Benefits

Program, the School Employees' Health Benefits Program, the qualified health plans in the federally run health exchange in the State, and other health benefits plans offered in the State.

h. Any other benchmarks or information obtained pursuant to this act that the commissioner deems appropriate to make publicly available to further the goals of the act.

15. a. There is established in the Department of the Treasury a nonlapsing revolving fund to be known as the "Healthcare Price Index Trust Fund." This fund shall be the repository for monies collected pursuant to subsection c. of this section and other monies received as grants or otherwise appropriated for the purposes of the index. The monies in the fund shall be used only to pay for administrative and operational expenses that the department incurs in order to carry out its responsibilities pursuant to this act, including funding the organization pursuant to the agreement between the department and the organization, and shall be specifically dedicated and utilized exclusively for this purpose.

b. The State Treasurer shall be the custodian of the fund, and all disbursements from the fund shall be made by the State Treasurer upon vouchers signed by the commissioner or the commissioner's designee. The monies in the fund shall be invested and reinvested by the Director of the Division of Investment in the Department of the Treasury as are other trust funds in the custody of the State Treasurer in the manner provided by law. Interest received on the monies in the fund shall be credited to the fund.

c. (1) The commissioner shall apply, and periodically revise as necessary, an annual surcharge to all health benefits plans, or to any third party administrators administering a health benefit plan, in the State, on a pro rata basis according to the number of covered persons in each health benefits plan, as the commissioner determines necessary to effectuate the purposes of this act.

(2) Any surcharges or assessments applied by the commissioner pursuant to paragraph (1) of this subsection shall not be fixed at a level that would generate revenue in excess of amounts necessary to effectuate the purposes of this act.

(3) The department and organization may charge a reasonable user fee to state entities and not for profit researchers for the right to access and use the data contained within the index; however, the fee may be reduced or waived for users that demonstrate a plan to use the data in research of general value to the public health or an inability to pay the scheduled fee, as provided in rules to be adopted by the commissioner.

(4) The department or organization may provide technical assistance to other public or private entities, for a fee, utilizing data released for the purposes of the index.

(5) The proceeds collected pursuant to this subsection shall be deposited into the fund.

(6) Information concerning monies collected pursuant to this subsection, including other monies received as grants or otherwise appropriated for the purposes of the index, and any fees collected for the right to access and use the data contained within the index, shall be disclosed and made available on the department website. The information shall be updated at least every 60 days.

d. The penalties collected pursuant to section 19 of this act shall be deposited into the fund.

16. a. Within 90 days of the effective date of this act, a carrier shall provide a written notice, in a form and manner to be prescribed by the Commissioner of Banking and Insurance, to each covered person of the protections provided to covered persons pursuant to this act. The notice shall include information on how a consumer can contact the department or the appropriate regulatory agency to report and dispute an out-of-network charge. The notice required pursuant to this section shall be posted on the carrier's website.

b. The commissioner shall provide a notice on the department's website containing information for consumers relating to the protections provided by this act and information on how consumers can report and file complaints with the department or the appropriate regulatory agency relating to any out-of-network charges.

17. a. The commissioner shall annually calculate the savings to each carrier that result from a reduction in out-of-network claims payments pursuant to the provisions of this act.

b. With respect to a carrier that is subject to a minimum loss ratio requirement, any savings to the carrier calculated pursuant to subsection a. of this section that result from the provisions of this act, shall be factored into any change in premiums collected for any policy form or benefit rider for the purpose of calculating the minimum loss ratio. In each case in which the loss ratio fails to substantially comply with the loss ratio requirement, including any noncompliance resulting from the savings to the carrier resulting from the provisions of this act, the carrier shall issue a dividend or credit against future premiums pursuant to the minimum loss ratio requirement.

18. a. It shall be a violation of this act if a health care provider, directly or indirectly related to a claim, knowingly waives, rebates, gives, pays, or offers to waive, rebate, give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider. As the commissioner shall prescribe by regulation, a pattern of waiving, rebating, giving or paying all or

part of the deductible, copayment or coinsurance by a provider shall be considered an inducement for the purposes of this subsection.

b. This section shall not apply to any waiver, rebate, gift, payment, or offer that falls within a safe harbor under federal laws related to fraud and abuse concerning patient cost-sharing, including, but not limited to, anti-kickback, self-referral, false claims, and civil monetary penalties.

19. a. A person or entity that violates any provision of this act, or the rules and regulations adopted pursuant hereto, shall be liable to a penalty as provided in this subsection. The penalty shall be collected by the commissioner in the name of the State in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

(1) A health care facility or carrier that violates any provision of this act shall be liable to a penalty of not more than $1,000 for each violation. Every day upon which a violation occurs shall be considered a separate violation, but no facility or carrier shall be liable to a penalty greater than $25,000 for each occurrence.

(2) In addition to any other existing penalties for such acts, a person or entity that receives data under the terms and conditions of this act and intentionally or knowingly uses, sells, or transfers the data for commercial advantage, pecuniary gain, personal gain, or malicious harm, in violation of rules which the commissioner shall adopt, shall be liable to a penalty of not more than $500,000 for each violation.

(3) A person or entity not covered by paragraphs (1) or (2) of this subsection that violates the requirements of this act shall be liable to a penalty of not more than $100 for each violation. Every day upon which a violation occurs shall be considered a separate violation, but no person or entity shall be liable to a penalty greater than $2,500 for each occurrence.

b. Upon a finding that a person or entity has failed to comply with the requirements of this act, including the payment of a penalty as determined under subsection a. of this section, the commissioner may:

(1) in the case of a carrier, initiate such action as the commissioner determines appropriate;

(2) in the case of a health care facility, refer the matter to the Commissioner of Health for such action as the Commissioner of Health determines appropriate; or

(3) in the case of a health care professional, refer the matter to the appropriate professional or occupational licensing board within the Division of Consumer Affairs in the Department of Law and Public Safety for such action as that board determines appropriate.

20. The Commissioner of Banking and Insurance, the Commissioner of Health and any relevant licensing board in the

Division of Consumer Affairs in the Department of Law and Public Safety under Title 45 of the Revised Statutes may, as appropriate, adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), in order to effectuate the purposes of this act.

21. Sections 9 through 11 and section 14 of this act shall take effect immediately and the remainder of this act shall take effect on the first day of the seventh month next following the date of enactment. The Commissioner of Banking and Insurance, the Department of Health and any relevant licensing board may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

STATEMENT

This bill is entitled the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.” The bill reforms various aspects of the health care delivery system in New Jersey to increase transparency in pricing for health care services, enhance consumer protections, create an arbitration system to resolve certain health care billing disputes, contain rising costs associated with out-of-network health care services, and measure success with regard to these goals.

DISCLOSURE

The bill places certain responsibilities on health care facilities and health care professionals to notify patients about services that they will provide. The bill uses the term “health care provider” to include both facilities and professionals.

Specifically, prior to scheduling an appointment with a covered person and at least 30 days prior to the procedure, a health care facility or health care professional must provide a written disclosure form to the covered person to inform the covered person if the provider is in-network or out-of-network with respect to the covered person’s health benefits plan and provide certain other information to help the consumer understand the costs associated with the procedure.

Providers, which are defined in the bill to include both facilities and professionals, are required to provide the covered person with a clear and understandable:

(1) description of the procedure;

(2) reasonable estimate of the costs for those services to be charged by that facility;

(3) information, if available, on all other costs related to the procedure including costs associated with any health care

professionals or other services involved in the procedure and, if unavailable, the fact that the information is unavailable; and

(4) notice to the covered person to contact the covered person's health insurance carrier for further consultation on the costs of the procedure.

The health care facility or professional must also, prior to the performance of the procedure, ensure that the covered person signs and returns the disclosure form, either electronically or in paper form.

The bill also places a variety of responsibilities on health insurance carriers. Carriers include insurance companies authorized to issue health benefits plans; health maintenance organizations; health, hospital, or medical service corporations; multiple employer welfare arrangements; entities providing or administering self-funded health benefits plans; entities under contract with the State Health Benefits Program and the School Employees' Health Benefits Program to administer a health benefits plan; and any other entity providing a health benefits plan.

Specifically, a carrier must disclose in writing to a covered person, at the time of enrollment in the plan, on the carrier's website, and upon request thereafter, for each health benefits plan offered in this State:

(1) a list of all providers that are in-network with respect to each health benefits plan that is updated at least every 20 days; and

(2) such other information as the Commissioner of Banking and Insurance determines appropriate and necessary to ensure that a covered person receives sufficient information necessary to make a well-informed health care decision.

The bill also addresses situations in which a carrier authorizes a covered health care service to be performed by an in-network health care provider with respect to any health benefits plan, and the provider or facility status changes to out-of-network before the authorized service is performed. The bill requires the carrier to notify the covered person that the provider or facility is no longer in-network as soon as practicable. If the carrier fails to provide the notice at least 30 days prior to the authorized service being performed, the covered person's financial responsibility shall be limited to the financial responsibility the covered person would have incurred had the provider been in-network with respect to the covered person's health benefits plan.

OUT-OF-NETWORK BILLING

The bill also places certain limitations on charges by out-of-network providers in two situations: (1) if a covered person receives medically necessary services at any health care facility on an emergency or urgent basis; and (2) inadvertent out-of-network services. The bill defines "inadvertent out-of-network services" to

mean health care services that are: covered under a managed care health benefits plan that provides a network; and provided by an out-of-network health care provider in the event that a covered person utilizes an in-network health care facility for covered health care services and, due to any reason, in-network health care services are unavailable in that facility.

The bill protects a covered person receiving medically necessary services at any health care facility on an emergency or urgent basis by prohibiting the provider from billing the covered person in excess of any deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person's health benefits plan.

With regard to the medically necessary services at an out-of-network health care facility on an emergency or urgent basis, the health care facility shall not bill the covered person's carrier in excess of an amount that is the maximum of a payment range established in the bill. If the carrier and facility cannot agree on a reimbursement rate for these services within 30 days after the carrier is billed for the service, the carrier or health care facility may initiate binding arbitration.

The bill also requires health care facilities that are in-network with respect to any health benefits plan to ensure that all providers providing services in the facility on an emergency or urgent basis accept reimbursement rates in accordance with the bill's provisions and to report certain information to the Department of Health.

The bill also provides that if a covered person receives:

a. inadvertent out-of-network services; or

b. medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis, the health care professional performing those services shall not bill:

(1) the covered person in excess of any deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person's health benefits plan; and

(2) the carrier in excess of an amount that is the maximum of the payment range established in the bill. If the carrier and the professional cannot agree on a reimbursement rate for these services within 30 days after the carrier is billed for the service, the carrier or professional may initiate binding arbitration.

HEALTHCARE PRICE INDEX

The bill establishes a Healthcare Price Index (HPI). The bill provides that the Commissioner of Banking and Insurance shall select an organization to maintain the HPI, in accordance with the terms of a written agreement which shall be entered into between the department and the organization. The commissioner is required to select an organization that possesses the capabilities to develop and implement policies and procedures for the collection,

processing, storage, and analysis of health care data in accordance with the provisions of the bill.

The purpose of the HPI is to serve as a useful, objective, reliable, and comprehensive health information index that is designed to:

(1) identify and electronically publish annually the list of median in-network paid commercial claims for the payment range as established in the bill; and

(2) make health care data available to the State and to not for profit researchers to improve health care quality, reduce health care costs, and increase pricing transparency.

Carriers shall file such health care data determined by the commissioner to be necessary to carry out the purposes of the bill. The form, medium, content, and frequency of the reporting shall be established by the commissioner but shall be reported at least annually.

The agreement between the department and the organization shall specify the form, medium, content, and frequency of reporting of the health care data, consistent with the bill, to the organization and reporting entities, as determined by the commissioner to be necessary to effectuate the bill's purposes.

ARBITRATION

For certain emergency and out-of-network billing situations between providers and carriers, the bill establishes an arbitration system with a payment range to be established by the HPI. The agreement between the department and the organization shall require the organization, upon review of the health care data submitted for the purposes of the HPI, to establish a list of median commercial paid in-network claims for health care services in New Jersey. Using the list, the organization must establish a reasonable and clearly defined payment range for any amount billed by an out-of-network health care provider and reimbursed by a carrier for out-of-network services provided on an emergency or urgent basis and as inadvertent out-of-network services. The payment range shall be between 75% and 250% of the median in-network paid commercial claim for a service, as identified by the list of in-network commercial paid claims created by the HPI.

In the event that a covered person receives inadvertent out-of-network services or services at an in-network or out-of-network health care facility on an emergency or urgent basis, the carrier shall ensure that the covered person incurs no greater out-of-pocket costs than the covered person would have incurred with an in-network health care provider for covered services. The out-of-network provider is prohibited from billing the covered person, except for applicable deductible, copayment, or coinsurance amounts that would apply if the covered person utilized an in-network health care provider for the covered services. In these

situations, a covered person may agree in writing to assign benefits that the covered person receives for health care services to the out-of-network health care provider. In the event that the benefits are assigned:

(1) any reimbursement paid by the carrier shall be paid directly to the out-of-network provider; and

(2) the carrier shall provide the out-of-network provider with a written explanation of benefits that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the covered person.

If inadvertent out-of-network services or medically necessary services at an in-network or out-of-network health care facility on an emergency or urgent basis are performed, the out-of-network provider may bill the carrier for the services rendered, in an amount that is within the payment range established by the HPI. The carrier may pay the billed amount or attempt to negotiate reimbursement with the out-of-network health care provider.

The bill establishes an arbitration system that utilizes the payment range established by the HPI. If attempts to negotiate reimbursement for services provided by an out-of-network health care provider do not result in a resolution of the payment dispute within 30 days after the carrier is billed for the services by the out-of-network health care provider, the carrier or out-of-network health care provider may initiate binding arbitration to determine payment for the services.

The binding arbitration system established under the bill provides that the party requesting arbitration shall notify the other party that arbitration has been initiated and state its final offer before arbitration. In response to this notice, the nonrequesting party shall inform the requesting party of its final offer before the arbitration occurs. Both final offers shall be within the payment range for the applicable service, as established by the organization, based on the organization's review of the HPI.

Arbitration shall be initiated by filing a request with the department. The arbitrators selected by the department shall be one or more entities that have experience in health care pricing.

The arbitrator's decision shall be one of the two amounts submitted by the parties as their final offers and shall be binding on both parties.

In making a determination, the arbitrator is to consider:

(1) in the case of a health care professional, the level of training, education, and experience of the health care professional;

(2) the health care provider's usual charge for comparable services provided out-of-network with respect to any health benefits plans;

(3) the circumstances and complexity of the particular case, including the time and place of the service;

(4) individual patient characteristics; and

(5) the usual and customary cost of the service, including the median commercial paid claim for that service as determined by the index.

The arbitration section is not available to a covered person who willfully chooses to access an out-of-network health care provider for health care services.

The bill also provides that on or before January 31 of each calendar year, the commissioner shall consult with the Board of Medical Examiners and the Department of Health to obtain information to compile and make publicly available certain information, on the department's website, including a list of all arbitrations filed, and an indication of whether the decision was in favor of the carrier or the out-of-network health care provider.

The bill also establishes in the Department of the Treasury a nonlapsing revolving fund to be known as the "Healthcare Price Index Trust Fund." This fund shall be the repository for monies collected pursuant to the bill's provisions and other monies received as grants or otherwise appropriated for the purposes of the index. The monies in the fund shall be used only to pay for administrative and operational expenses that the department incurs in order to carry out its responsibilities pursuant to this bill, including funding the organization pursuant to the agreement between the department and the organization, and shall be specifically dedicated and utilized exclusively for this purpose.

The commissioner is charged with applying, and periodically revising as necessary, an annual surcharge to all health benefits plans, or to any third party administrators administering a health benefit plan, in the State, on a pro rata basis according to the number of covered persons in each health benefits plan, as the commissioner determines necessary to effectuate the purposes of the bill. These surcharges or assessments applied by the commissioner shall not be fixed at a level that would generate revenue in excess of amounts necessary to effectuate the purposes of the bill.

The department and organization may also charge a reasonable user fee for the right to access and use the data contained within the index; however, the fee may be reduced or waived for users that demonstrate a plan to use the data in research of general value to the public health or an inability to pay the scheduled fee, as provided in rules to be adopted by the commissioner. The department and organization are also permitted to provide technical assistance to other public or private entities, for a fee, utilizing data released for the purposes of the index.

Information concerning monies collected pursuant to the bill, including monies received as grants or otherwise appropriated for the purposes of the index, and any fees collected for the right to access and use the data contained within the index, shall be

disclosed and made available on the department website. The information shall be updated at least every 60 days.

The bill provides that within 90 days of its effective date, a carrier shall provide a written notice to each covered person of the protections provided to covered persons pursuant to the bill. The notice shall include information on how a consumer can contact the department or the appropriate regulatory agency to report and dispute an out-of-network charge. The notice shall be posted on the carrier's website.

The bill provides that the commissioner shall annually calculate the savings to each carrier that results from a reduction in out-of-network claims payments pursuant to the provisions of the bill and ensure that any savings to the carrier that results from the provisions of the bill shall be factored into any change in premiums collected for any policy form or benefit rider for the purpose of calculating the minimum loss ratio. In each case in which the loss ratio fails to substantially comply with the loss ratio requirement, including any noncompliance resulting from the savings to the carrier resulting from the provisions of the bill, the carrier shall issue a dividend or credit against future premiums pursuant to the minimum loss ratio requirement.

WAIVER OF CO-PAYS

The bill also provides that it is a violation of the bill's provisions if a health care provider, directly or indirectly related to a claim, knowingly waives, rebates, gives, pays, or offers to waive, rebate, give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider. The bill specifies that a pattern of waiving, rebating, giving or paying all or part of the deductible, copayment or coinsurance by a provider shall be considered an inducement. The bill provides that this section does not apply to any waiver, rebate, gift, payment, or offer that falls within a safe harbor under federal laws related to fraud and abuse concerning patient cost-sharing, including, but not limited to, anti-kickback, self-referral, false claims, and civil monetary penalties. One such safe harbor is for a financial hardship.

PENALTIES

A person or entity that violates any provision of the bill, or the rules and regulations adopted pursuant thereto, is liable to a penalty as provided in the bill. Further, upon a finding that a person or entity has failed to comply with the requirements of the bill, including the payment of a penalty, the commissioner may:

(1) in the case of a carrier, initiate such action as the commissioner determines appropriate;

(2) in the case of a health care facility, refer the matter to the Commissioner of Health for such action as the Commissioner of Health determines appropriate; or

(3) in the case of a health care professional, refer the matter to the appropriate professional and occupational licensing board within the Division of Consumer Affairs in the Department of Law and Public Safety for such action as that board determines appropriate.